APPLICATION FOR A LIMITED DENTAL RESIDENCY PERMIT

INDIANA STATE BOARD OF DENTISTRY
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2054
Email: pla8@pla.in.gov
www.pla.IN.gov

***Your Social Security number is requested by the agency in accordance with IC 4-1-8-1. Disclosure is mandatory and this record cannot be processed without it.**

FOR OFFICE USE ONLY	
PERMIT NUMBER	
PERMIT ISSUE DATE *(month, day, year)*	
PERMIT EXPIRATION DATE (month, day, year)	

APPLICANT

Attach one (1) passport type quality photograph of yourself taken within the last eight weeks. Please sign he photo at the bottom.

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant *(last, first, middle, maiden)*		***Social Security number**
Address *(number and street or rural route number)*		
City	State	Zip Code
Date of Birth *(month, day, year)*	**Place of Birth** *(city, state or country)*	
Telephone Number *(daytime)*	**Email Address**	

DEGREE GRANTED BY:

Name of School	Location of School	Date of Graduation (month, day, year)
☐ **DDS** ☐ **DMD**		
Is this school accredited by the Commission on Accreditation of the American Dental Association? ☐ **Yes** ☐ **No**		

PREDENTAL EDUCATION

Name of School	Location of School	Date of Graduation (month, day, year)

POSTGRADUATE DENTAL EDUCATION
(include Internships, residencies and/or fellowships)

Name of School/Program	Location of School	From (month, year)	To (month, year)

EXAMINATIONS

Check appropriate boxes indicating which examinations you have taken.

	EXAMINATION	DATE ADMINISTERED
	National Board Dental Examination	
	North East Regional Board Examination (NERB)	
	Central Regional Dental Test Service (CRDTS)	
	Southern Regional Testing Agency (SRTA)	
	Western Regional Examining Board (WREB)	
	State Board Examination Which State? _____	
	Canadian Examination. _____	
	Other: _____	

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM DENTAL SCHOOL

Please list all states in which you have been licensed to practice any regulated Health Occupation.

GENERAL LOCATION	FROM (month, year)	TO (month, year)

STATE(S) OF LICENSURE

Please list all states in which you have been licensed to practice any regulated Health Occupation.

STATE	TYPE OF LICENSE, CERTIFICATE, OR REGISTRATION	NUMBER	DATE ISSUED (month, year)	DATE EXPIIRED (month, year)	CURRENT STATUS

EMPLOYMENT HISTORY

List all places of employment since graduation from Dental School. If additional space is needed, please make additional copies of this page and attach to application.

Employer #1

Name of Employer		Name of Facility	
Employer Address (number and street or rural route number			
City	State	Zip Code	
Hours Worked Per Week	Dates Worked	From (month, day, year)	To (month, day, year)
Employment Responsibilities: (List all responsibilities regarding this employment)			

Employer #2

Name of Employer		Name of Facility	
Address (number and street or rural route number			
City	State	Zip Code	
Hours Worked Per Week	Dates Worked	From (month, day, year)	To (month, day, year)
Employment Responsibilities: (List all responsibilities regarding this employment)			

Employer #3

Name of Employer		Name of Facility	
Address (number and street or rural route number			
City	State	Zip Code	
Hours Worked Per Week	Dates Worked	From (month, day, year)	To (month, day, year)
Employment Responsibilities: (List all responsibilities regarding this employment)			

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s), case information, detailed description of case/events and settlement amount, including court documents, if applicable. Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.	
1. Has any healthcare license, certificate, registration, or permit you hold or have held been subject to investigation, charges pending or disciplinary sanctions?	☐ Yes ☐ No
2. Has any license to practice dentistry in any state, (including Indiana), or country been denied, withdrawn, revoked, or suspended for disciplinary sanctions?	☐ Yes ☐ No
3. Have you been censured, issued a letter of reprimand, received probationary status, had restrictions or limitation placed on your ability to perform certain acts within the practice of dentistry in any state (including Indiana) or country?	☐ Yes ☐ No
4. Are you now being, or have you ever been treated for drug or alcohol abuse or addiction?	☐ Yes ☐ No
5. Have you ever been the subject of an investigation by a regulatory agency concerning any healthcare license, certificate, registration, or permit?	☐ Yes ☐ No
6. Have you ever been conviction of, plead guilty or *nolo contendere* to, or are criminal charges pending to:	
A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction?	☐ Yes ☐ No
B. Any offense, misdemeanor or felony in any state? (Except for minor violations of traffic laws resulting in fines.)	☐ Yes ☐ No
7. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	☐ Yes ☐ No
8. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	☐ Yes ☐ No
9. Have you ever had a malpractice judgment against you or settled any malpractice action?	☐ Yes ☐ No
10. Have you had any action, discipline or revocation of a DEA (U.S. Drug Enforcement Administration) registration or entered into a Memorandum of Understanding (MOU) on said registration?	☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	**Date signed (month, day, year)**

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorized, request and direct any person, firm officer, corporation, association, organization or institution to release to the Professional licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency, or any of its authorized representatives in connection with processing my application for a limited dental residency permit.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned organizations, persons, and institutions from any information which is material to my application, and I hereby specifically release the Agency and Board from any and all liability in connection with such disclosure.

A photo static copy of this authorization haws the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Signature of applicant	**Date signed (month, day, year)**

VERIFICATION OF ENROLLMENT
FOR A LIMITED DENTAL RESIDENCY PERMIT

Return Completed Form To:

Indiana State Board of Dentistry
Indiana Professional Licensing Agency
402 West Washington Street, Room W072
Indianapolis, Indiana 46204

*** Your Social Security number is requested by this agency in accordance with IC 4-1-8-1, and it is mandatory that it be given.**

THIS SECTION TO BE COMPLETED BY THE APPLICANT		
Name of applicant ***(last, first, middle, maiden)***		***Social Security number**
Address ***(number and street or rural route number)***		
City	State	Zip Code
Date of Birth ***(month, day, year)***	**Place of Birth** ***(city, state or country)***	
Telephone Number ***(daytime)***	**Email Address**	

THIS SECTION TO BE COMPLETED BY THE SCHOOL		
Name of School	**Name of Department**	
Address ***(number and street or rural route number)***		
City	State	Zip Code
Contact Person	**Title**	
Telephone Number ***(daytime)***	**Email Address**	
Date of Residency begins (month, day, year)	**Date of Residency ends (month, day, year)**	

AFFIRMATION

I hereby swear or affirm that the applicant listed above is enrolled in a residency or fellowship program and is using the permit only for school purposes. Information provided herein is true and correct.

Dean/Department Chair	**Title**	
Address (number and street)		
City	**State**	**Zip code**
Telephone Number	**Email Address**	
Signature of Dean/Department Chair	**Date Signed (month, day, year)**	